STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676187	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage House of Marshall Health & Rehabilitation	5915 Elysian Fields Road Marshall, TX 75672

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review, the facility failed to implement written policies and procedures that prohibit and prevent abuse, neglect, exploitation, or mistreatment of residents for 1 of 4 residents (Resident #1) reviewed for abuse and neglect. The facility failed to suspend an alleged perpetrator immediately following an accusation of abuse. This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. The findings included: Record review of the facility's policy and procedure, titled Reporting Abuse and Neglect Policy, revision date March 2018, .'With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee will immediately be suspended pending an investigation' .'The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 .a. If the allegations involve abuse or result in serious bodily injury, the report is made within 2 hours of the allegation. If the allegations do not result in serious bodily injury, the report is made within 24 hours of the allegation. 1. Record review of Resident #1's face sheet, dated 06/11/2024 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included COPD (chronic obstructive pulmonary disease-is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety (overwhelming feeling of anxiousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.) Record review of Resident #1's admission MDS assessment, dated 05/04/2024 revealed Resident #1 had a BIMS score of 14, which indicated no cognitive impairment. It also indicated Resident #1 required substantial to maximum assistance with ADLs such as bed mobility. Record review of Resident #1's comprehensive care plan, edit date 06/09/2024 listed the problem: Resident #1 had a history of making false accusations of abuse and neglect. The intervention was listed as, the facility would investigate any negative resident reports. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2024 at 1:25 p.m., Resident #1 stated CNA B had a bad attitude and yanked her around in her bed when she was changing her. Resident #1 stated CNA B would not engage in conversation with her. Resident #1 stated CNA B does not want to mess with me because I am not going to tolerate her crap. Resident #1 stated after the yanking had occurred she called family member E and she came up to the facility. Record review and interview on 06/11/2024 at 2:00 p.m., of witness statement #1 written by LVN A dated 06/08/2024 indicated: At approximately 10:12 a.m., LVN A and Weekend RN supervisor were in room (of Resident #1) for AM medications. Resident #1was very upset and talking mean and aggressive about CNA B on duty. I do not know what is wrong with her today, but I am not going to take that. LVN A stated she asked Resident #1 what was wrong and why she was so upset. Resident #1 continued to say that CNA B was being disrespectful and snatching her across the bed. LVN A asked Resident #1 if she was hurt. Resident #1 replied, no but I'm not going to take that from her or nobody. LVN A stated she finished her med pass (15 minutes) and immediately reported the situation to the Administrator by phone and the weekend on call nurse, also by phone. LVN A stated she reported the allegations to the administrator around 10:40 a.m. on 06/08/2024 and requested the Administrator call the family member of Resident #1 because she was highly upset. LVN A stated she reported to the administrator that Resident #1 felt like CNA B was rough during care and snatched her around in the bed. Record review and interview on 06/12/2024 at 9:10 a.m., of witness statement #2 written by RN C dated 06/08/2024 9:50 a.m. (late entry) indicated Resident #1 complained to her on 06/08/2024 at 9:50 a.m. that CNA B had a bad attitude during AM care and was jerking her around and also refused to adjust her pillow as she wanted. RN C stated Resident #1 was on the phone with a family member while she was reporting this to her. Resident #1 had a video camera in her room and the family member stated she would review the footage and call RN C back. RN C stated around 10:20 a.m. Resident #1's family called her back and asked that CNA B be removed from caring for [Resident #1]because she had not liked the way CNA B handled her [Resident #1] care. RN C stated she removed CNA B from hall 300 and put her on hall 400. Resident #1's family stated if something was not done about CNA B's attitude, she would go higher than the administrator with her complaints. RN C stated she notified the Administrator (abuse coordinator) of the conversation with Resident #1's family member at 10:30 a.m. During an interview on 06/11/2024 at 2:30 p.m., CNA B stated she was suspended on 06/10/2024 after being written up for poor customer service. CNA B stated she was moved to a different hallway on 06/08/2024 and 06/09/2024. CNA B stated she was never asked to leave and never told there was an abuse allegation against her until 06/10/2024 when the Administrator suspended her pending an investigation of abuse. During an interview on 06/11/2024 at 12:15 p.m., the family member of Resident #1 stated she was called by Resident #1 and asked to review the video footage from her room on 06/08/2024 from 9:00 a.m. to 10:00 a.m. to see how mean CNA B was to Resident #1. Resident #1's family member stated she reviewed the footage and felt CNA B was acting erratically. She stated she came in and out of the room over a dozen times during one episode of incontinent care and she was being rough with Resident #1 when turning and repositioning her. She stated CNA B needed more training. She stated she spoke with RN C over the phone on 06/08/2024 and told her to remove CNA B from the building or she would go higher than the Administrator to protect the rights of the resident at the facility. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/11/2024 at 12:40 p.m., Resident #1's family member allowed the surveyor to view 32 clips of footage from 06/08/2024 from 9:00 a.m. to 10:00 a.m. ranging from 14 seconds to 2 1/2 minutes in length. No definitive occurrences of abuse occurred during the transactions viewed. The videos showed CNA B offering to brush Resident #1's teeth, arriving with her breakfast tray and setting her up to eat in a comfortable position, removing her breakfast tray, providing incontinent care, and repositioning her multiple times in the bed with different pillow arrangements per Resident #1's request. During an interview on 06/12/2024 at 11:00 a.m., the Administrator stated it was reported to her on 06/08/2024 around 10:30 a.m., that Resident #1 was having an issue with CNA B. The Administrator stated no one ever said the words 'jerking around in bed' or 'snatching around in bed'. The Administrator stated it was reported to her that Resident #1 was having a bad day and could not get along with CNA B. The Administrator continued by saying it was not unusual for Resident #1 to have a bad day and mistreat the staff. The Administrator stated Resident #1 was having a hard time adjusting to long term care and wanted her family to take her home, but the family refused to do so. The Administrator stated Resident #1 often took her frustration out on the staff. She said had it been reported to her that Resident #1 felt like she was being snatched or jerked around in the bed she would have suspended CNA B immediately and started her investigation instead of waiting until 06/10/2024 to begin. The Administrator stated as soon as she saw the statements with those words in them, she suspended CNA B and called the incident in to HHSC. The Administrator stated it was the policy of the facility to suspend immediately and call HHSC within 24 hours if no injury is sustained. The Administrator stated not following this policy could result in resident abuse and neglect occurring or continuing to occur in the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview and record review the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 of 6 residents (Resident #1) reviewed for abuse and neglect. The facility failed to report Resident #1's abuse allegation within 24 hours to the state agency. This failure could place residents at risk for continued abuse and neglect due to inappropriate interventions and failure to report the allegations of abuse timely. The findings included: Record review of the facility's policy and procedure, titled Reporting Abuse and Neglect Policy, revision date March 2018, .'With an allegation of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property, the employee will immediately be suspended pending an investigation' .'The facility administrator or designee will report to HHSC all incidents that meet the criteria of Provider Letter 19-17 .a. If the allegations involve abuse or result in serious bodily injury, the report is made within 2 hours of the allegation. If the allegations do not result in serious bodily injury, the report is made within 24 hours of the allegation. Record review of Resident #1's face sheet, dated 06/11/2024 revealed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that included COPD (chronic obstructive pulmonary disease-is a chronic inflammatory lung disease that causes obstructed airflow from the lungs), anxiety (overwhelming feeling of anxiousness), and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life.) Record review of Resident #1's admission MDS assessment, dated 05/04/2024 revealed Resident #1 had a BIMS score of 14, which indicated no cognitive impairment. It also indicated Resident #1 required substantial to maximum assistance with ADLs such as bed mobility. Record review of Resident #1's comprehensive care plan, edit date 06/09/2024 listed the problem: Resident #1 had a history of making false accusations of abuse and neglect. The intervention was listed as, the facility would investigate any negative resident reports. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/11/2024 at 1:25 p.m., Resident #1 stated CNA B had a bad attitude and yanked her around in her bed when she was changing her. Resident #1 stated CNA B would not engage in conversation with her. Resident #1 stated CNA B does not want to mess with me because I am not going to tolerate her crap. Resident #1 stated after the yanking had occurred she called her family member E and she came up to the facility. Record review and interview on 06/11/2024 at 2:00 p.m., of witness statement #1 written by LVN A dated 06/08/2024 indicated: At approximately 10:12 a.m., LVN A and Weekend RN supervisor were in room (of Resident #1) for AM medications. Resident #1was very upset and talking mean and aggressive about CNA B on duty. I do not know what is wrong with her today, but I am not going to take that. LVN A stated she asked Resident #1 what was wrong and why she was so upset. Resident #1 continued to say that CNA B was being disrespectful and snatching her across the bed. LVN A asked Resident #1 if she was hurt. Resident #1 replied, no but I'm not going to take that from her or nobody. LVN A stated she finished her med pass (15 minutes) and immediately reported the situation to the Administrator by phone and the weekend on call nurse, also by phone. LVN A stated she reported the allegations to the administrator around 10:40 a.m. on 06/08/2024 and requested the Administrator call the family member E because she was highly upset. LVN A stated she reported to the administrator that Resident #1 felt like CNA B was rough during care and snatched her around in the bed. Record review and interview on 06/12/2024 at 9:10 a.m., of witness statement #2 written by RN C dated 06/08/2024 9:50 a.m. (late entry) indicated Resident #1 complained to her on 06/08/2024 at 9:50 a.m. that CNA B had a bad attitude during AM care and was jerking her around and also refused to adjust her pillow as she wanted. RN C stated Resident #1 was on the phone with a family member while she was reporting this to her. Resident #1 had a video camera in her room and family member E stated she would review the footage and call RN C back. RN C stated around 10:20 a.m. Family member E called her back and asked that CNA B be removed from caring for [Resident #1]because she had not liked the way CNA B handled her [Resident #1] care. RN C stated she removed CNA B from hall 300 and put her on hall 400. Resident #1's family stated if something was not done about CNA B's attitude, she would go higher than the administrator with her complaints. RN C stated she notified the Administrator (abuse coordinator) of the conversation with family member E at 10:30 a.m. During an interview on 06/11/2024 at 2:30 p.m., CNA B stated she was suspended on 06/10/2024 after being written up for poor customer service. CNA B stated she was moved to a different hallway on 06/08/2024 and 06/09/2024. CNA B stated she was never asked to leave and never told there was an abuse allegation against her until 06/10/2024 when the Administrator suspended her pending an investigation of abuse. During an interview on 06/12/2024 at 11:00 a.m., the Administrator stated it was reported to her on 06/08/2024 around 10:30 a.m., that Resident #1 was having an issue with CNA B. The Administrator stated no one ever said the words 'jerking around in bed' or 'snatching around in bed'. The Administrator stated it was reported to her that Resident #1 was having a bad day and could not get along with CNA B. She said had it been reported to her that Resident #1 felt like she was being snatched or jerked around in the bed she would have suspended CNA B immediately and started her investigation instead of waiting until 06/10/2024 to begin. The Administrator stated as soon as she saw the statements with those words in them, she suspended CNA B and called the incident in to HHSC. The Administrator stated it was the policy of the facility to suspend immediately and call HHSC within 24 hours if no injury is sustained. The Administrator stated not following this policy could result in resident abuse and neglect occurring or continuing to occur in the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44596 Based on observation, interview, and record review, the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for 1 of 3 residents (Resident #2) reviewed for accidents and supervision, in that: Resident #2 was transferred with only (1) staff member using a mechanical hydraulic lift by CNA D causing her foley catheter to become dislodged spilling urine on the resident and causing pain to Resident #2 by not supporting her right fractured leg that was non-weight bearing on 06/10/2024. This failure could place residents who are transferred by mechanical hydraulic lift at risk for avoidable accidents and could result in a decline in physical condition. The findings included: Record review of Resident #2's face sheet, dated 06/12/2024, revealed Resident #2 was admitted to the facility on [DATE] with the diagnoses of fracture of right tibia (broken bone in the lower part of right leg), pneumonia (lung infection), and urinary retention (inability to empty the bladder completely when voiding). Resident review of Resident #2's care plan, with care plan completed date of 06/06/2024, revealed a care plan for : ADL performance deficit: Resident #2 required dependent assist of 2 staff members for ADLs such as transfer and bed mobility. Record review of Resident #2's admission MDS, indicated no MDS was completed for this resident at this time. Record review of Resident #2's Kardex (ADL guide for CNA use), indicated Resident #2 was a 2 person Hoyer (hydraulic lift) transfer only. Record review of Resident #2's physician orders dated 06/11/2024, indicated Resident #2 was non-weight bearing to her right leg and it was to remain in a brace at all times for healing. The physicians' orders also indicated Resident #2 had a foley catheter for urinary retention. During an observation on 06/10/2024 at 1:00 p.m., surveyor heard a loud scream coming from 300 hall. Upon arrival to the open doorway, surveyor noted CNA D transferring Resident #2 alone with a Hoyer (mechanical hydraulic lift). Resident #2's foley catheter bag was attached to the chair and Resident #2 was lifted above the wheelchair about 12 inches. This caused the foley catheter to come undone at the attachment point and urine was leaking all over the resident, her chair, and the floor. Resident #2 was repeatedly saying someone get my leg, please get my leg. Resident #2's fractured leg in a brace was unsupported during that the time of the transfer. CNA D lowered Resident #2 back into the chair and the DOR entered, Resident #2's room to assist with the transfer from the wheelchair into the bed. The DOR supported and guided Resident #2's right leg while she was transferred to the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/10/2024 at 1:50 p.m., CNA D stated she knew that Resident #2 probably required 2 people when transferring. CNA D stated she knew how to look up resident information up in the Kardex to see how many staff were needed with each ADL. She stated she had not taken the time to look because Resident #2's family had asked her 5 times in 5 minutes to hurry and put her in bed because she was tired. CNA D stated she worked for agency and had been oriented to the facility. CNA D stated she had worked at the facility over a dozen times during the last 6 months. CNA D stated she was unaware if it was the policy of the facility to always have 2 people when using a mechanical lift. CNA D stated she transferred people safely all the time with mechanical lifts by herself in the facility. She stated she had to because she could not always find someone willing to assist her. CNA D stated management was aware there was only one CNA on 300 hall, because that is how they staffed the hall. CNA D stated she could see now why Resident #2 required 2 staff members during transfer, someone needed to support her leg and make sure her catheter made it to the bed with her and was not left on the chair. During an interview on 06/10/2024 at 2:15 p.m., Resident #2 stated she was always transferred with only one person with the mechanical lift and she was scared of the lift. She stated no one had ever hurt her, but it was hard for them to manage her leg and get her transferred without bumping into things. Resident #2 stated it would be much better and she would feel safer if the staff would use 2 people to transfer her. She stated she was not in pain from the transfer to bed, it just scared her when the catheter broke apart and urine went everywhere. During an interview on 06/10/2024 at 3:00 p.m., the DON stated it was the facility policy with mechanical lifts to always have 2 people for safety. The DON stated it was in Resident#2's Kardex to have 2 people for all transfers. The DON stated agency staff was given an orientation when they worked their first shift at the facility to introduce them to the CNA documentation system and familiarize them with how to read the Kardex. The DON stated it was her responsibility to oversee that the CNAs were using proper lifting techniques. The DON stated not having 2 people for Resident #2's transfer with a mechanical lift could have reinjured her fractured leg, could have pulled her foley catheter out, and could have caused her injury and pain. During an interview on 06/11/2024 at 12:00 p.m., the Administrator stated it was the facility's policy to follow the safest recommendations of the manufacturer on how many people it took to transfer someone from a chair to the bed. The Administrator stated Resident #2's care plan stated 2 people for her transfer and CNA D should have used 2 people for the transfer. The Administrator stated she could not speak to what the negative outcomes of having a one-person mechanical lift transfer would be. Review of FDA 'Guidelines to Hoyer Transfer', retrieved 06/10/2024 at 3:45p.m., https://www.fda.gov/files/medical%20devices/published/Patient-Lifts-Safety-Guide.pdf, indicated, the safest practice for Hoyer transfers was to use 2 people. One person was required to operate the machine and the other assists and guarded the patient against injury. In instances of negligent operation, the machine may tip over with the resident in it or a loop on the sling may dislodge from the machine causing the resident to fall to the floor. The second person is there to prevent serious injury to the resident. Residents sometimes become agitated and a second person should be there to help stabilize the sling. The battery may also lose power during a transfer. A second person could go get another battery while the first person stays with the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an undated facility policy titled Hydraulic Lift revealed the goals of using a hydraulic lift are .1. The resident will achieve safe transfer to bed or chair via a mechanical lift device. 2. The caregiver will demonstrate and correct transfer of the resident to the bed or chair via the hydraulic lift. 3. The resident will verbalize a decrease in anxiety following explanation of the procedure.